Child A (a minor suing through his mother and litigation representative, Cheah Chai Yuen) & Ors v Pengarah Hospital Tuanku Ja'afar, Seremban & Ors

HIGH COURT (SEREMBAN) — CIVIL SUIT NO NA21NCVC-11–10 OF 2020
AZIZUL AZMI ADNAN J
18 APRIL 2024

Tort — Negligence — Medical negligence — Child suffered cerebral palsy — Child and parents sued director of hospital, government and medical practitioners for medical negligence — Whether defendants breached duty of care — Whether doctors in attendance lacked requisite skill and experience — Whether director of hospital and government failed to establish standard operating procedures for maternity emergencies in hospital — Whether there was a failure to adhere to applicable guidelines issued by Ministry of Health — Whether consent of child's mother was improperly obtained — Whether doctor failed to properly monitor fetal heart rate in accordance with accepted standards and the Perinatal Care Manual issued by Ministry of Health — Whether there was a delay by defendants to carry out Emergency Lower Segment Caesarean Section — Whether there was vicarious liability on part of government

This was an action brought by a minor ('the first plaintiff') through his father ('the second plaintiff') and mother ('the third plaintiff') against certain members of staff ('the defendants') of Hospital Tuanku Ja'afar, Seremban ('the hospital') for negligence related to the circumstances of his birth. In this regard, the first plaintiff suffered from cerebral palsy. It was the plaintiffs' case that the negligence on the part of the defendants had led to cerebral hypoxia and ultimately to the condition from which the first plaintiff suffered. As against the first and second defendants (who were the director of the hospital and the government of Malaysia respectively), the plaintiffs had pleaded ten contentions of negligence. The third to twentieth defendants were health care practitioners (doctors and nurses) attached to the hospital at the material time. Against them, the plaintiffs pleaded a further 34 counts of negligence. However, cases against 15 of the defendants were abandoned by the plaintiffs. The plaintiffs had only maintained their case against the first and second defendants as well as the following three doctors: (a) Dr Siti Aziemah bt Jahaya (DW4, the Registrar On-Call who had delivered the baby); (b) Dr Norhafizi bt Madzaki (DW5, the On-Call Specialist who had made the decision to carry out the Emergency Lower Segment Caesarean Section ('ELSCS')); and (c) Dr Shyamala Ponnuthurai (DW3, the doctor who had been assigned to carry out the Caesarean section). The plaintiffs contended that: (i) the defendants had

breached their duty of care to the plaintiffs by the fact that the doctors in attendance lacked the requisite skill and experience; (ii) the first and second defendants failed to establish standard operating procedures ('the SOP') for maternity emergencies in the hospital, and that there was a failure to adhere to the applicable guidelines issued by the Ministry of Health ('the MOH'); (iii) the contents of the consent form had not been explained to the third plaintiff and was not translated into Chinese and that the consent ought to have been obtained at the Patient Assessment Centre rather than the labour room; (iv) DW3 had failed to properly monitor fetal heart rate in accordance with accepted standards and the Perinatal Care Manual issued by the MOH; and (v) there had been a delay on the part of the relevant defendants to carry out the ELSCS and that this delay had breached the duty of care owed to the first and third plaintiffs. There were also other contentions of breach of duty against DW3 and DW4 for their alleged breach of the relevant procedures. The defendants in the present case denied that there had been any breach of a duty of care owed to the first and third plaintiffs.

Held, dismissing the plaintiffs' claim with costs of RM10,000:

(1) It was well established in law that an attending physician would owe a duty of care to his or her patient. In the present case, the defence did not attempt to argue that the defendants did not owe a duty of care to the plaintiffs. However, the court was of the view that the second plaintiff, as the father of the baby, was not owed a duty of care by the attending physicians, as he was not their patient. The first defendant in this case was the director of the hospital. The director of a hospital, as the head of the hospital, would directly owe a duty of care to the patients of the hospital. The after-trial written submissions for the plaintiffs offered no arguments on the liability of the six nurses and of nine of the 12 doctors who were made defendants in the action. The court considered the cases against these 15 defendants as having been abandoned (see paras 36–37, 50–51 & 54–55).

(2) In relation to the contention that the defendants had breached their duty of care to the plaintiffs by the fact that the doctors in attendance lacked the requisite skill and experience, the court found that: (a) the contention that the doctors were not appropriately qualified or experienced had not been made out, as both doctors who attended to the patient in the operating theatre had been duly credentialed to undertake ELSCS; (b) the credentialing process also meant that doctors would have been duly trained to perform both the push and the pull methods of extraction once they have received their certification; (c) the plaintiffs failed to prove that there was a requirement either in the operating procedures of the hospital or those issued by the MOH that required the On-call Specialist to undertake ELSCS; and (d) even if DW3 failed to keep a copy of the log

of the procedures that she had undertaken, this failure could not be said to be the proximate cause of the injury to the first plaintiff (see paras 38 & 66–68).

(3) In relation to the plaintiffs' contention that the first and second defendants failed to establish the SOP for maternity emergencies in the hospital, and that there was a failure to adhere to the applicable guidelines issued by the MOH, the court was of the view that this contention was not proven because: (a) the present case did not fall within any of the categories that justified the initiation of the Red Alert procedures; (b) hence any failure on the part of the defendants to promulgate Red Alert procedures for the hospital (in purported contravention with the guidelines issued by the MOH) would not be relevant in the present case, because this was not a Red Alert case; and (c) the plaintiffs failed to demonstrate that the manner in which the Department of Obstetrics and Gynaecology at the hospital recorded its clinical procedures were in contravention of guidelines issued by the MOH (see paras 39 & 76).

(4) With respect to the plaintiffs' contention that consent was improperly obtained, the court found that: (a) the fact that the consent of the third plaintiff was obtained in the labour room, and not in the Patient Assessment Centre, did not constitute a breach of a duty of care that was owed to the third plaintiff or to the first plaintiff, because in the present case, the decision to carry out the ELSCS was made when the third plaintiff was in the labour room, and not when she was in the Patient Assessment Centre; (b) the plaintiffs failed to discharge the evidential burden of proving that the risks and complications associated with an ELSCS had not been explained to the third plaintiff before the procedure was carried out, as the third plaintiff herself was not sure whether an explanation had been given to her — in this regard, the court found that the third plaintiff's contention that she could not understand Malay was not true, on the basis of evidence to the contrary from DW5; and (d) even if there had been breach of the duty to obtain the informed consent of the patient, the injury complained of did not arise from that breach of duty (see paras 40 & 83).

(5) In relation to the contention that DW3 had failed to properly monitor fetal heart rate in accordance with accepted standards and the Perinatal Care Manual issued by the MOH, the court found that this contention was not made out because: (a) the requirements of the Perinatal Care Manual had in fact been adhered to by the defendants, as cardiotocography and doppler fetal rate readings had been taken within the prescribed timeframes; and (b) the court preferred the views of the defendant's obstetrics and gynaecology expert over that of the plaintiff, because the latter had come to the conclusion that the monitoring of fetal heart rate was sub-standard based on the mistaken premise that fetal heart

rate readings had not been taken after 1940hrs, when in fact at least two further Daptone readings were taken before commencement of surgery (see paras 41 & 96).

(6) The court was of the view that the plaintiffs' contention that there had been a delay on the part of the relevant defendants to carry out the ELSCS and that this delay had breached the duty of care owed to the first and third plaintiffs had not been made out. This finding was based on the following reasons: (a) based on the evidence that had been received regarding the cardiotocography traces, the court found that the cardiotocography readings were merely suspicious and not abnormal, and that the fetus suffered acute bradycardia and not persistent bradycardia; (b) the case ought thus to have been classified in Category 2 in accordance with the guidelines issued by the UK National Institute for Health and Care Excellence, indicating maternal or fetal compromise which was not immediately life-threatening; and (c) by these guidelines, the decision-to-delivery interval for Category 2 cases was 75 minutes. The delivery in this case was effected in 50 minutes, which established that there was no delay on the part of the defendants that contravened any duty of care owed to the first or third plaintiffs (see paras 42 & 122).

(7) The court was of the view that there were no breaches of duty arising from the contended failure of DW4 to monitor or observe the third plaintiff after the decision to carry out the ELSCS was made or to inform the On-Call Specialist immediately upon receiving the second call, or from the contended failure by DW3 to ask the Registrar On-Call to come immediately instead of asking her to be on standby and in proceeding with the Caesarean section on her own. The reason was that there were no procedures that were breached by reason of the actions of the two doctors. Further, the court found that the contention that DW3 had failed to ring the alarm when she could not deliver the baby was not made out on the facts (see paras 43(a), (b) & 126–127).

(8) The court found that the contentions that DW3 had failed: (a) to put the plaintiff in a lithotomy position to facilitate the push method to address the impacted fetal head; (b) to lower the operating table in order to facilitate delivery; (c) to administer a uterine relaxant to the third plaintiff; and (d) to carry out intrauterine fetal resuscitation in order to increase blood flow to the fetus, prior to undertaking the ELSCS, were all not pleaded in the statement of claim, and in the case of (a) and (d) above, had not been put to DW3 in the course of cross-examination. Further, the allegation that DW3 had physically injured the baby in the course of delivery had not been proven by the plaintiffs in the course of trial, and that in any event, even if there had been bruises to the baby's body and limbs as a result of the ELSCS, these injuries had not caused the cerebral

palsy from which the first plaintiff suffered, and which formed the subject matter of the claim (see paras 43(c), (d) & 128–129). A

(9) As none of the contentions of breach of duty was made out against the director of the hospital, DW4, DW5 or DW3, it followed that there was no vicarious liability on the part of the government (see paras 44 & 133). B

[Bahasa Malaysia summary

Ini adalah tindakan yang dibawa oleh seorang kanak-kanak bawah umur ('plaintif pertama') melalui bapa ('plaintif kedua') dan ibunya ('plaintif ketiga') terhadap anggota kakitangan tertentu ('defendan-defendan') Hospital Tuanku Ja'afar, Seremban ('hospital tersebut') kerana kecuaian berkaitan keadaan kelahirannya. Dalam hal ini, plaintif pertama menghidapi palsi serebrum. Kes plaintif-plaintif adalah bahawa kecuaian di pihak defendan-defendan telah membawa kepada hipoksia serebrum dan akhirnya kepada keadaan yang dihidapi oleh plaintif pertama. Plaintif-plaintif telah memplid sepuluh dakwaan kecuaian terhadap defendan pertama dan kedua (masing-masing adalah pengarah hospital dan kerajaan Malaysia). Defendan ketiga hingga ke-20 adalah pengamal penjagaan kesihatan (doktor-doktor dan jururawat-jururawat) yang bertugas di hospital tersebut pada masa itu. Plaintif-plaintif memplid 34 lagi pertuduhan kecuaian terhadap mereka. Bagaimanapun, kes terhadap 15 defendan telah ditinggalkan oleh plaintif-plaintif. Plaintif-plaintif hanya mengekalkan kes mereka terhadap defendan pertama dan kedua serta tiga doktor berikut: (a) Dr Siti Aziemah bt Jahaya (DW4, Pendaftar On-Call yang telah menyambut kelahiran bayi tersebut); (b) Dr Norhafizi bt Madzaki (DW5, Pakar On-Call yang telah membuat keputusan untuk menjalankan 'Emergency Lower Segment Caesarean Section' ('ELSCS')); dan (c) Dr Shyamala Ponnuthurai (DW3, doktor yang telah ditugaskan untuk menjalankan pembedahan Caesarean tersebut). Plaintif-plaintif berhujah bahawa: (i) defendan-defendan telah melanggar kewajipan berjaga-jaga mereka ke atas plaintif-plaintif berdasarkan fakta bahawa doktor-doktor yang bertugas tidak mempunyai kemahiran dan pengalaman yang diperlukan; (ii) defendan pertama dan kedua gagal membuat prosedur operasi standard ('SOP') untuk kecemasan bersalin di hospital tersebut, dan bahawa terdapat kegagalan untuk mematuhi garis panduan yang terpakai yang dikeluarkan oleh Kementerian Kesihatan ('KKM'); (iii) kandungan borang persetujuan tidak dijelaskan kepada plaintif ketiga dan tidak diterjemahkan ke dalam bahasa Cina dan bahawa persetujuan tersebut sepatutnya diperolehi di Pusat Penilaian Pesakit dan bukannya bilik bersalin; (iv) DW3 telah gagal memantau kadar denyutan janin dengan betul mengikut piawaian yang diterima dan Perinatal Care Manual yang dikeluarkan oleh KKM; dan (v) telah berlaku kelewatan di pihak defendan-defendan yang berkaitan untuk menjalankan ELSCS dan bahawa kelewatan ini telah melanggar kewajipan berjaga-jaga mereka terhadap plaintif pertama dan ketiga. Terdapat juga pertikaian-pertikaian lain terhadap DW3 dan DW4 C D E F G H I

mengenai pelanggaran kewajipan berdasarkan dakwaan bahawa mereka melanggar prosedur-prosedur yang berkaitan. Defendan-defendan dalam kes ini menafikan bahawa terdapat apa-apa pelanggaran kewajipan berjaga-jaga terhadap plaintif pertama dan ketiga.

Diputuskan, menolak tuntutan plaintif-plaintif dengan kos sebanyak RM10,000:

(1) Telah ditetapkan dalam undang-undang bahawa doktor yang merawat akan mempunyai tanggungjawab berjaga-jaga ke atas pesakitnya. Dalam kes ini, pihak pembelaan tidak cuba untuk berhujah bahawa defendan-defendan tidak mempunyai kewajipan berjaga-jaga ke atas plaintif-plaintif. Bagaimanapun, mahkamah berpendapat bahawa doktor-doktor yang merawat tidak mempunyai kewajipan berjaga-jaga ke atas plaintif kedua, sebagai bapa kepada bayi tersebut, kerana dia bukan pesakit mereka. Defendan pertama dalam kes ini ialah pengarah hospital tersebut. Pengarah sebuah hospital, sebagai ketua hospital, secara langsung mempunyai kewajipan berjaga-jaga kepada pesakit hospital. Hujahan bertulis selepas perbicaraan plaintif-plaintif tidak memberikan hujah mengenai liabiliti enam jururawat dan sembilan daripada 12 doktor yang dijadikan defendan dalam tindakan semasa. Mahkamah menganggap kes terhadap 15 defendan ini sebagai telah ditinggalkan (lihat perenggan 36–37, 50–51 & 54–55).

(2) Berhubung dengan hujahan bahawa defendan-defendan telah melanggar kewajipan berjaga-jaga mereka ke atas plaintif-plaintif berdasarkan fakta bahawa doktor-doktor yang merawat tidak mempunyai kemahiran dan pengalaman yang diperlukan, mahkamah mendapati bahawa: (a) dakwaan bahawa doktor-doktor tersebut tidak mempunyai kelayakan atau pengalaman yang sepatutnya gagal dibuktikan, kerana kedua-dua doktor yang merawat pesakit di dewan bedah telah diberi kelayakan sewajarnya untuk menjalankan ELSCS; (b) proses pemberian kelayakan tersebut juga bermakna bahawa doktor-doktor tersebut telah dilatih dengan sewajarnya untuk melakukan kedua-dua kaedah tolakan dan tarikan pengekstrakan sebaik sahaja mereka menerima pensijilan mereka; (c) plaintif-plaintif gagal membuktikan bahawa terdapat keperluan sama ada dalam prosedur operasi hospital atau yang dikeluarkan oleh KKM yang memerlukan Pakar On-Call untuk menjalankan ELSCS; dan (d) walaupun DW3 gagal menyimpan salinan log prosedur yang telah dijalankannya, kegagalan ini tidak boleh dikatakan sebagai punca terdekat bagi kecederaan yang menimpa plaintif pertama (lihat perenggan 38 & 66–68).

(3) Berhubung dengan dakwaan plaintif-plaintif bahawa defendan pertama dan kedua gagal membuat SOP bagi kecemasan bersalin di hospital tersebut, dan bahawa terdapat kegagalan untuk mematuhi garis panduan

yang terpakai yang dikeluarkan oleh KKM, mahkamah berpendapat bahawa dakwaan ini tidak dibuktikan kerana: (a) kes ini tidak termasuk dalam mana-mana kategori yang mewajarkan permulaan prosedur Red Alert; (b) oleh itu apa-apa kegagalan di pihak defendan-defendan untuk melaksanakan prosedur Red Alert untuk hospital tersebut (yang dikatakan melanggar garis panduan yang dikeluarkan oleh KKM) tidak akan relevan dalam kes ini, kerana ini bukan kes Red Alert; dan (c) plaintif-plaintif gagal menunjukkan bahawa cara Jabatan Obstetrik dan Ginekologi di hospital tersebut merekodkan prosedur klinikalnya adalah bercanggah dengan garis panduan yang dikeluarkan oleh KKM (lihat perenggan 39 & 76).

(4) Berkenaan dengan dakwaan plaintif-plaintif bahawa persetujuan diperoleh secara tidak wajar, mahkamah mendapati bahawa: (a) fakta bahawa persetujuan plaintif ketiga diperoleh di dalam bilik bersalin, dan bukan di Pusat Penilaian Pesakit, tidak membentuk pelanggaran kewajipan berjaga-jaga terhadap plaintif ketiga atau plaintif pertama, kerana dalam kes ini, keputusan untuk menjalankan ELSCS telah dibuat apabila plaintif ketiga berada di dalam bilik bersalin, dan bukan semasa dia berada di Pusat Penilaian Pesakit; (b) plaintif-plaintif gagal untuk melepaskan beban keterangan untuk membuktikan bahawa risiko dan komplikasi yang berkaitan dengan ELSCS tidak dijelaskan kepada plaintif ketiga sebelum prosedur dijalankan, kerana plaintif ketiga sendiri tidak pasti sama ada penjelasan telah diberikan kepadanya — dalam hal ini, mahkamah mendapati dakwaan plaintif ketiga bahawa dia tidak memahami bahasa Melayu adalah tidak benar, berdasarkan keterangan DW5 yang menyatakan sebaliknya; dan (d) jika pun telah berlaku pelanggaran kewajipan untuk mendapatkan persetujuan termaklum pesakit, kecederaan yang diadukan tidak timbul daripada pelanggaran kewajipan tersebut (lihat perenggan 40 & 83).

(5) Berhubung dengan dakwaan bahawa DW3 telah gagal memantau kadar denyutan jantung janin dengan betul mengikut piawaian yang diterima dan Perinatal Care Manual yang dikeluarkan oleh KKM, mahkamah mendapati bahawa dakwaan ini gagal dibuktikan kerana: (a) kehendak Perinatal Care Manual sebenarnya telah dipatuhi oleh defendan-defendan, kerana kardiotokografi dan bacaan kadar janin doppler telah diambil dalam tempoh masa yang ditetapkan; dan (b) mahkamah lebih cenderung untuk bersetuju dengan pandangan pakar obstetrik dan ginekologi defendan berbanding plaintif, kerana mahkamah telah membuat kesimpulan bahawa pemantauan kadar denyutan jantung janin adalah sub-standard berdasarkan anggapan yang salah bahawa bacaan kadar denyutan jantung janin tidak diambil selepas jam 1940, sedangkan sebenarnya sekurang-kurangnya dua bacaan Daptone selanjutnya diambil sebelum memulakan pembedahan (lihat perenggan 41 & 96).

(6) Mahkamah berpendapat bahawa dakwaan plaintif-plaintif bahawa terdapat kelewatan di pihak defendan-defendan yang berkaitan untuk menjalankan ELSCS dan bahawa kelewatan ini telah melanggar kewajipan berjaga-jaga terhadap plaintif pertama dan ketiga adalah tidak dibuktikan. Dapatan ini adalah berdasarkan sebab-sebab berikut: (a) berdasarkan keterangan yang telah diterima mengenai jejak kardiotokografi, mahkamah mendapati bahawa bacaan kardiotokografi adalah mencurigakan semata-mata dan bukan abnormal, dan bahawa janin mengalami bradikardia akut dan bukan bradikardia yang berterusan; (b) kes tersebut sepatutnya telah diklasifikasikan dalam Kategori 2 mengikut garis panduan yang dikeluarkan oleh UK National Institute for Health and Care Excellence, yang menunjukkan kompromi ibu atau janin yang tidak mengancam nyawa dengan serta-merta; dan (c) mengikut garis panduan ini, selang keputusan untuk bersalin bagi kes Kategori 2 ialah 75 minit. Proses bersalin dalam kes ini dilaksanakan dalam masa 50 minit, yang membuktikan bahawa tiada kelewatan di pihak defendan-defendan yang melanggar apa-apa kewajipan berjaga-jaga terhadap plaintif pertama atau ketiga (lihat perenggan 42 & 122).

(7) Mahkamah berpendapat bahawa tiada pelanggaran kewajipan yang timbul daripada kegagalan DW4 untuk memantau atau memerhati plaintif ketiga selepas keputusan untuk menjalankan ELSCS dibuat atau memaklumkan kepada Pakar On-Call dengan segera selepas menerima panggilan kedua, atau daripada dakwaan kegagalan oleh DW3 untuk meminta Pendaftar On-Call datang dengan segera dan bukannya memintanya untuk bersiap sedia dan meneruskan Pembedahan Caesar secara bersendirian. Ini kerana, tiada prosedur yang telah dilanggar menerusi tindakan kedua-dua doktor tersebut. Selanjutnya, mahkamah mendapati bahawa dakwaan bahawa DW3 telah gagal membunyikan penggera apabila dia tidak dapat menyambut kelahiran bayi tersebut tidak dibuktikan berdasarkan fakta (lihat perenggan 43(a), (b) & 126–127).

(8) Mahkamah mendapati bahawa dakwaan bahawa DW3 telah gagal: (a) meletakkan plaintif dalam kedudukan litotomi untuk memudahkan kaedah tolakan untuk menangani kepala janin yang terjejas; (b) menurunkan meja operasi untuk memudahkan proses bersalin; (c) untuk menyuntik relaksan rahim kepada plaintif ketiga; dan (d) untuk menjalankan resusitasi janin dalam rahim untuk meningkatkan aliran darah ke janin, sebelum menjalankan ELSCS, semuanya tidak diplid dalam pernyataan tuntutan, dan dalam kes (a) dan (d) di atas, tidak dinyatakan kepada DW3 semasa pemeriksaan balas. Selanjutnya, dakwaan bahawa DW3 telah mencederakan bayi tersebut secara fizikal semasa proses bersalin tidak dibuktikan oleh plaintif-plaintif semasa perbicaraan, dan bahawa dalam apa jua keadaan, walaupun terdapat

kesan lebam pada tubuh badan dan anggota badan bayi tersebut akibat daripada ELSCS, kecederaan ini tidak menyebabkan palsi serebrum yang dihidapi oleh plaintif pertama, dan yang membentuk perkara dalam tuntutan (lihat perenggan 43(c), (d) & 128–129).

(9) Memandangkan tiada satu pun dakwaan tentang pelanggaran kewajipan dibuktikan terhadap pengarah hospital, DW4, DW5 atau DW3, maka, tiada liabiliti vikarius di pihak kerajaan (lihat perenggan 44 & 133).]

Cases referred to

Aik Ming (M) Sdn Bhd & Ors v Chang Ching Chuen & Ors and another appeal [1995] 2 MLJ 770; [1995] 3 CLJ 639, CA (refd)
Bolam v Friern Hospital Management Committee [1957] 2 All ER 118, QBD (refd)
Bolitho v City and Hackney Health Authority [1997] 3 WLR 1151, HL (refd)
Browne v Dunn (1893) 6 R 67, HL (refd)
Child A (a minor suing through his mother and litigation representative, Cheah Chai Yuen) & Ors v Pengarah Hospital Tuanku Ja'Afar, Seremban & Ors [2023] 7 MLJ 603; [2022] 7 CLJ 391, HC (refd)
Foo Fio Na v Dr Soo Fook Mun & Anor [2007] 1 MLJ 593; [2007] 1 CLJ 229, FC (refd)
Pekan Nenas Industries Sdn Bhd v Chang Ching Chuen & Ors [1998] 1 MLJ 465; [1998] 1 CLJ 793, FC (refd)
Pengarah Hospital Selayang & Ors v Ahmad Azizi bin Abdullah James & Ors [2012] 5 MLJ 679; [2013] 3 CLJ 833, CA (refd)
Roe v Ministry of Health and another [1954] 2 QB 66, QBD (refd)
Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors [2017] 5 MLJ 438; [2017] 8 CLJ 605, FC (refd)

Legislation referred to

Congenital Disabilities (Civil Liability) Act 1976 [UK]
Evidence Act 1950 s 57(2)

Harmindar Singh Dhillon (with Sharannya Sundaramoorthy) (HS Dhillon & Co) for the plaintiffs.
Uma Devi Balasubramaniam (Senior Federal Counsel, Attorney General's Chambers) for the defendants.

Azizul Azmi Adnan J:

INTRODUCTION

[1] The first plaintiff is a minor. He suffers from cerebral palsy. Through his mother and litigation representative, he sued certain members of staff of Hospital Tuanku Ja'afar in Seremban for medical negligence related to the

circumstances of his birth. The second and third plaintiffs are the first plaintiff's father and mother respectively. It was the plaintiffs' case that the negligence on the part of the defendants had led to cerebral hypoxia and ultimately to the condition from which the first plaintiff suffers.

[2] After a full trial of the action, I dismissed the plaintiffs' claims. The reasons for this decision is recorded here.

[3] The names of the plaintiffs have been anonymised in this judgment for reasons of privacy. Footnotes have been used extensively in order to make reference to specific passages in the trial bundles, witness statements and the notes of evidence (**Editorial note**: As the Malayan Law Journal does not use footnotes as part of our reporting format, information from the mentioned footnotes are inserted in parentheses at the relevant portion of text).

MATERIAL FACTS

[4] The third plaintiff, Madam C, became pregnant with her second child in January 2017. The due date for the pregnancy was 30 October 2017. She had initial medical consultations with a private medical clinic in Tebrau, Johor. She subsequently registered with the government clinic in Plentong, also in Johor. On 23 October 2017, she had an antenatal examination at Klinik Kesihatan Mambau, in Negeri Sembilan. She chose to give birth at Hospital Tuanku Ja'afar because her first child was delivered there and because her mother's house was in Seremban. The delivery date was scheduled for 30 October 2017.

[5] On 27 October 2017, Madam C went to the hospital because she was experiencing pain. She was accompanied by her sister.

At the Patient Assessment Centre

[6] At Hospital Tuanku Ja'afar, Madam C was attended to at the Patient Assessment Centre first by the house officer on duty, Dr Tham Sheau Huoy. Madam Cheah was then examined by Dr Joanne Lim Xu Mei (DW2), who was a registered medical officer working in the department of obstetrics and gynaecology in the hospital. A foetal heart rate check was undertaken using a Daptone (a foetal doppler monitor), which showed the baby's heart rate to be 130 beats per minute (bpm). Madam C was diagnosed as being in the latent phase of labour and was sent to Ward Kenanga 4B at 1900hrs.

Ward Kenanga 4B

[7] At Ward Kenanga 4B, Madam C was attended to by Dr Muhammad Fahmi Rossman (DW1), who was a house officer at the material time. A

cardiotocography was undertaken at 1903hrs (see p 1448 of Bundle B10 of the trial bundles) to record foetal heart rate. Dr Fahmi undertook an analysis of the cardiotocography trace at about 1925hrs, which showed that, even though the baseline heart rate of the baby was normal, his heart rate had dropped to 60 bpm twice over a period of ten minutes. Dr Fahmi categorised the cardiotocography reading as *suspicious*.

[8] At trial, the court was referred to the *Perinatal Care Manual* issued by the Ministry of Health. This manual explains the categorisation of cardiotocography readings. The relevant portion of the *Perinatal Care Manual* (see B5/813 of the trial bundles) is reproduced below:

Interpretation of Cardiotocography (CTG)

Normal
- Baseline rate 110 bpm – 160 bpm
- Baseline variability 5 bpm – 25 bpm
- Two accelerations in 20 minutes
- No deceleration

Suspicious
Absence of accelerations and one of the following:
- Abnormal baseline rate (<110 bpm or >160 bpm)
- Reduced baseline variability < 10 bpm for more than 40 minutes
- Variable decelerations without ominous features

Abnormal
Absence of accelerations and any of the following:
- Abnormal baseline rate and variability (< 5 bpm for more than 40 minutes)
- Repetitive late decelerations
- Variable decelerations with ominous features:
  - Duration over 60 seconds
  - Beat loss over 60 bpm
- Late recovery
- Late deceleration component
- Poor baseline variability between and/or during decelerations

Sinusoidal pattern
- Prolonged bradycardia (<100 bpm) for longer than 3 minutes
- Shallow decelerations with reduced baseline variability (< 5 bpm) in a non-reactive trace

[9] The *Perinatal Care Manual* divided cardiotocography readings into four categories: *normal*, *suspicious*, *abnormal* and *sinusoidal*. Dr Fahmi explained

A that he had categorised the cardiotocography reading as *suspicious* because there was an absence of accelerations in the heart rate of the fetus, combined with the two drops in the heart rate below the baseline.

B **[10]** Dr Fahmi undertook a vaginal examination and thereafter briefed Dr Siti Aziemah bt Jahaya (DW4, an obstetrics and gynaecology specialist who was also the registrar of the obstetrics and gynaecology department of the hospital), requesting that the patient be sent to the labour room. Dr Fahmi played no further part in the treatment of the mother or her baby.

C *In the labour room*

[11] Madam C arrived at the labour room at approximately 1930hrs, where she was attended to again by Dr Joanne Lim (DW2). The foetal heart rate upon
D arrival at the labour room was 124 bpm. Dr Lim noted the cardiotocography trace that had been started at 1933hrs, which showed foetal bradycardia (heart rate being below the normal range) down to 60 bpm with a slow recovery to a baseline foetal heart rate of 140 bpm (see B10/1451).

E **[12]** Both the cardiotocography traces adduced at trial were recorded on what appeared to be thermal paper (similar to those used for older facsimile machines), which resulted in the readings not being very clear at the time of trial. With the help of the witnesses, however, the court was able to discern the drops in the foetal heart rate in both cardiotocography traces, and its
F subsequent recovery to the baseline. As we shall see, the expert obstetrics and gynaecology witnesses in this case had been given photocopies of the cardiotocography traces which were for all intents and purposes illegible, which affected their testimonies at trial.

G **[13]** At trial, Dr Joanne Lim explained that the foetal heart rate had dropped to 60 bpm for about one minute and then recovered back to its baseline. The heart rate dropped just once over the course of the 1933hrs cardiotocography trace. Dr Lim was of the view that the bradycardia was not *persistent* because the
H heart rate did not stay abnormally low for at least three minute (see pp 240 and 242 of the Notes of Evidence).

[14] After conducting a vaginal examination, Dr Lim found Madam C to be in the active phase of labour with the opening in the centre of the cervix being
I 6cm. In her view, the clinical assessment showed that there was foetal distress and delivery needed to be carried out as soon as possible. She called Dr Nurhafizi bt Madzaki (the on-call specialist, DW5) at approximately 1940hrs to consult on the mode of delivery. Dr Nurhafizi decided, based on the suggestion by Dr Lim, that an Emergency Lower Segment Caesarean Section

would be undertaken. The level of urgency in the patient's clinical situation was classed as Category 2 (indicating maternal or foetal compromise that was not immediately life-threatening).

[15] One of the contentions in the plaintiffs' pleaded case was that the defendants had failed to obtain the consent of Madam C prior to the procedure. However, in her witness statement tendered at trial, she conceded that she had signed the consent form at B1/126 of the trial bundles (by which she assented to the Emergency Lower Segment Caesarean Section). Nonetheless, she maintained in her witness statement that the contents of the form had not been explained to her, although as we shall see, she wavered when cross-examined on this point. The consent form was signed at 1940hrs.

[16] Madam C was then sent to the operating theatre. At 1945hrs, a Daptone reading showed that the foetal heart rate was 141 bpm (see Q&A 20 of WSD2). Dr Joanne Lim played no further part in the treatment of Madam C or the baby.

At the operating theatre

[17] Madam C arrived at the operating theatre at approximately 1950hrs, where the attending surgeon was Dr Shyamala Ponnuthurai (DW3). The foetal heart rate was 135 bpm, which indicated that the bradycardia episode had passed. Because of this, Madam C was given a spinal anaesthetic. The epidural anaesthesia was administered by Dr Mardhiyyah bt Mazlan (DW6). The associated risks of anaesthesia were explained by DW6 to Madam C and her agreement was recorded at about 1950hrs.

[18] Dr Shyamala commenced the Emergency Lower Segment Caesarean Section at approximately 2012hrs. Thirty two minutes had elapsed from when the decision was made for a surgical delivery.

[19] In the course of undertaking the surgery, Dr Shyamala discovered fibroids in the patient's lower uterine segment. She was not previously made aware of their presence. She nonetheless proceeded to make an incision above the upper margin of the fibroids. The events were described in Dr Shyamala's witness statement in following manner:

> Semasa ingin memulakan pembedahan ke atas pesakit, saya mendapati bahawa terdapat beberapa ketulan fibroid berukuran 2x3cm dan 3x3cm, di bahagian lower segment pesakit.
>
> Pada jam lebih kurang 2016H, saya telah mengarahkan Circulating Nurse bertugas untuk membuat panggilan kepada registrar on-call iaitu Dr Siti Aziemah bt Jahaya, bagi memaklumkan tentang keadaan pesakit yang mempunyai fibroid dan berisiko untuk mengalami pendarahan.

A Kemudian, saya meneruskan pembedahan dengan memotong di bahagian atas fibroid dan mendapati bahawa bayi pesakit dalam keadaan *cephalic presentation ([occiput posterior] position), head deeply engaged unable to deliver despite disengagement of foetal head from below*.

B **[20]** As explained in her witness statement, a call was made to the registrar on-call, Dr Siti Aziemah bt Jahaya (DW4) at 2016hrs to inform her of the discovery of fibroids in the patient's lower segment.

C **[21]** Dr Shyamala attempted to undertake the push technique to remove the baby, whose head had become deeply engaged on the cervix. She was not successful. At 2020hrs, Dr Shyamala directed the circulating nurse on duty to make a second call to the registrar on-call, Dr Siti Aziemah. Dr Siti Aziemah arrived seven minutes later.

D **[22]** When she received the call, Dr Siti Aziemah was on the third floor of the hospital, in the antenatal ward. The operating theatre was located on the ground floor. As the lifts were slow, Dr Siti Aziemah ran down the stairs.

E **[23]** The baby was delivered by Dr Siti Aziemah at 2030hrs, just three minutes after she had arrived at the operating theatre. She used the reverse breech extraction method. The umbilical cord had to be cut before delivery of the baby. Dr Siti Aziemah observed in her notes (B1/119) that the umbilical cord was tight across both of the baby's hips.

F **[24]** From the time the decision was made to perform an Emergency Lower Segment Caesarean Section until the delivery of the baby, 50 minutes had elapsed.

G **[25]** The subsequent surgery on Madam C was completed by Dr Shyamala.

[26] The baby was passed to Dr Naveen Nair of the paediatric department (DW7), who was called to be on standby at the maternity operating theatre. At
H trial, Dr Naveen Nair described the baby's condition as limp with low heart rate, poor tone, poor respiratory effort upon delivery. He performed resuscitation on the baby, which he described in the following terms:

I I did the initial resuscitation steps following the Neonatal Resuscitation Program (NRP) ie dry the baby, tactile simulation and followed by Positive Pressure Ventilation (PPV) per protocol. However, I realized the baby still had heart rate less than 60 beats per minute (bpm), poor breathing efforts and poor tone. With no improvement from the baby, I proceeded with intubation at 1 minute of life Endotracheal tube (ETT) size 3.0mm, anchored at 9cm to secure the airway. However after intubation, heart rate was still less than 60 bpm, so I commenced

Cardiopulmonary Resuscitation (CPR) 2 cycle, for a total of 2 minutes. The heart rate then picked up, baby is pink and movements seen in the baby.

The Apgar score of the baby was 4 at 1 minute of the life, 6 at 5 minutes of life and 8 at 10 minutes of life. In normal healthy infant, Apgar score should be more than 9 at 5 minutes.

[27] The first plaintiff was subsequently diagnosed with spastic quadriplegic cerebral palsy due to hypoxic ischaemic encephalopathy and possible infantile stroke.

ISSUES

The plaintiffs' pleaded case

[28] The plaintiffs' pleaded case was cast broadly. As against the first and second defendants (who were the director of the hospital and the government of Malaysia respectively), the plaintiffs had pleaded ten contentions of negligence. The third to twentieth defendants were health care practitioners (doctors and nurses) attached to the hospital at the material time. Against them, the plaintiffs pleaded a further 34 counts of negligence.

The case after trial

[29] The evidence received at trial showed that, of the 12 doctors named as defendants in the statement of claim, two of them had no involvement at all in the advice, diagnosis or treatment of Madam C. The after-trial written submissions for the plaintiffs also contained no allegations of breach of duty against these two doctors as well as against a further seven doctors. Similarly, no case was levelled in the written submissions against the six nurses named as defendants in the statement of claim. Thus the cases against these 15 defendants were taken to have been abandoned.

[30] The case was maintained against five defendants: the director of the hospital, the government of Malaysia and the following three doctors:

(a) Dr Siti Aziemah bt Jahaya (DW4, the registrar on-call who had delivered the baby);

(b) Dr Norhafizi bt Madzaki (DW5, the on-call specialist who had made the decision to carry out the Emergency Lower Segment Caesarean Section); and

(c) Dr Shyamala Ponnuthurai (DW3, the doctor who had been assigned to carry out the Caesarean section).

[31] The specific contentions of breach of duty can be grouped into the following six categories:

(a) *doctors lacking in skill and experience*: the contended failure by the first and second defendants to engage appropriately skilled obstetricians and gynaecologists. Among others, the plaintiffs alleged that Dr Shyamala did not have the requisite skill or experience to carry out the delivery of a baby with a deeply impacted head;

(b) *no SOP for maternity cases, failure to follow MOH Guidelines*: the contended failure by the first and second defendants to establish standard operating procedures for maternity cases, as well as the failure to adhere to applicable guidelines issued by the Ministry of Health;

(c) *consent improperly obtained*: it was contended that, in connection with the consent obtained from Madam C:

(i) the contents of the consent form and the risks and complications associated with the Emergency Lower Segment Caesarean Section were not adequately explained to Madam C;

(ii) the consent form was not translated to Madam C in a Chinese dialect; and

(iii) the consent of Madam C ought to have been obtained at the Patient Assessment Centre rather than the labour room;

(d) *failure to monitor foetal heart rate*: the contended failure by Dr Shyamala to monitor foetal heart rate immediately before commencing surgery and the failure to take a reading of the foetal heart rate between 1953hrs and 2012hrs;

(e) *delay in carrying out delivery*: the contended delay in carrying out the delivery which breached the requisite standard of care. The plaintiffs' case was that delivery ought to have been completed within 30 minutes of the decision having been made to undertake the Emergency Lower Segment Caesarean Section. Specifically, it was alleged (among others) that:

(i) Dr Nurhafizi failed to carry out the Caesarean section personally;

(ii) Dr Siti Aziemah ought to have attended at the operating theatre immediately upon receiving the first call at 2016hrs when she was informed of the existence of fibroids, and that the seven minutes that she had taken to run from the antenatal ward on the third floor to the operating theatre on the ground floor of the hospital constituted a delay in contravention of her duty of care; and

(iii) Dr Shyamala failed to deliver the baby within the time prescribed by the applicable standard of care and ought to have requested the presence of Dr Siti Aziemah earlier than 2020hrs;

(f) *other contentions of the plaintiff*: the plaintiffs raised a number of other,

disparate, contentions in the written submissions. These were as follows:

(i) as against Dr Siti Aziemah, it was alleged that she had breached her duty of care to the plaintiffs:

(1) when she failed to monitor or observe the third plaintiff after the decision to carry out the Emergency Lower Segment Caesarean Section was made; and

(2) when she failed to inform the on-call specialist immediately upon receiving the second call at 2020hrs.

(ii) as against Dr Shyamala, it was further advanced for the plaintiffs that Dr Shyamala had breached her duty of care to the plaintiffs:

(1) when she failed to ask the registrar on-call to come immediately instead of asking her to be on standby; and

(2) by not waiting for the Registrar, and instead proceeding with the Caesarean section on her own;

(3) by failing to ring the alarm when she could not deliver the baby;

(4) when she failed to put the plaintiff in a lithotomy position to facilitate the push method to address the impacted foetal head;

(5) when she failed to lower the operating table in order to facilitate delivery;

(6) when she failed to administer a uterine relaxant to the third plaintiff;

(7) by not carry out intrauterine foetal resuscitation in order to increase blood flow to the fetus, prior to undertaking the Emergency Lower Segment Caesarean Section; and

(8) by physically injuring the baby in the course of delivery.

The defence

[32] The totality of the statement of defence in substance constituted a denial that there had been any breach of a duty of care owed to the first and third plaintiff.

[33] In her witness statement, Dr Shyamala testified that the existence of fibroids in the womb caused complications to the delivery (see Q&A 12 of WSD3) and that the surgical procedure would have been different had she been given prior notice of their existence (Q&A 22 of WSD3). However, this had never been the defendants' pleaded case. Indeed, according to the

A statement of defence, the treatment received by Madam C would have been the same even if the presence of fibroids was known to the hospital staff (para 17 of the defence, at IP/41).

B **[34]** The existence of the fibroids thus had never been put into issue, and was not material to the determination of the merits of the claim.

SUMMARY OF THE COURT'S FINDINGS

C **[35]** The findings of the court are summarised as follows.

The existence of a duty of care

D **[36]** It is well established in law that an attending physician would owe a duty of care to his or her patient. In this case, the defence did not attempt to argue that the defendants did not owe a duty of care to the plaintiffs. However, I was of the view that the second plaintiff, as the father of the baby, was not owed a duty of care by the attending physicians, as he was not their patient.

E **[37]** The after-trial written submissions for the plaintiffs offered no arguments on the liability of the six nurses and of nine of the 12 doctors who were made defendants in the action. I considered the cases against these 15 defendants as having been abandoned (see para 50–56, post).

F *Doctors allegedly lacking in skill and experience*

[38] In relation to the contention that the defendants had breached their duty of care to the plaintiffs by the fact that the doctors in attendance lacked the requisite skill and experience, the court found that:

G (a) the contention that the doctors were not appropriately qualified or experienced had not been made out, as both doctors who attended to the patient in the operating theatre had been duly credentialed to undertake an Emergency Lower Segment Caesarean Section;

H (b) the credentialing process also meant that doctors would have been duly trained to perform both the push and the pull methods of extraction once they have received their certification;

(c) the plaintiffs failed to prove that there was a requirement either in the I operating procedures of the hospital or those issued by the Ministry of Health that required the on-call specialist to undertake an Emergency Lower Segment Caesarean Section;

(d) on the contended failure of Dr Shyamala to keep a copy of the log of the procedures that she had undertaken: even if she had failed to do so, this

failure cannot be said to be the proximate cause of the injury to the first plaintiff. A
(see paras 57–68, post.)

No emergency procedures for maternity cases; contended failure to follow MOH Guidelines B

[39] In relation to contention of the plaintiffs that the first and second defendants (being the director of the hospital and the government of Malaysia respectively) failed to establish standard operating procedures for maternity emergencies in Hospital Tuanku Ja'afar, and that there was a failure to adhere to applicable guidelines issued by the Ministry of Health, I was of the view that this contention was not made out because: C

(a) the present case did not fall within any of the categories that justified the initiation of the Red Alert procedures; D

(b) hence any failure on the part of the defendants to promulgate Red Alert procedures for Hospital Tuanku Ja'afar (in purported contravention with the guidelines issued by the Ministry of Health) would not be relevant in the present case, because this was not a Red Alert case; and E

(c) the plaintiffs failed to demonstrate that the manner in which the Department of Obstetrics and Gynaecology at the hospital recorded its clinical procedures were in contravention of guidelines issued by the Ministry of Health.
(see paras 69–76, *post*.) F

Consent improperly obtained

[40] In relation to the contentions of the plaintiffs that the contents of the consent form had not been explained to Madam C and was not translated into Chinese and that the consent ought to have been obtained at the Patient Assessment Centre rather than the labour room, I found that: G

(a) the fact that the consent of Madam C was obtained in the labour room, and not in the Patient Assessment Centre, did not constitute a breach of a duty of care that was owed to Madam C or to the first plaintiff, because in this case, the decision to carry out the Emergency Lower Segment Caesarean Section was made when Madam C was in the labour room, and not when she was in the Patient Assessment Centre; H

(b) the plaintiffs failed to discharge the evidential burden of proving that the risks and complications associated with an Emergency Lower Segment Caesarean Section had not been explained to Madam C before the procedure was carried out, as Madam C herself was not sure whether an explanation had been given to her. I further found that Madam C's I

A contention that she could not understand Malay not to be true, on the basis of evidence to the contrary from Dr Nurhafizi (DW5); and

(c) in any event, the question of informed consent was not material to the real issue at hand: it was not the plaintiffs' case that Madam C would have refused consent had the risks of the procedure been adequately explained to her. The plaintiffs' complaint was that the hospital personnel had breached their duty of care by the manner in which the Emergency Lower Segment Caesarean Section was carried out, and not that Madam C was exposed to a risk that she would not have voluntarily undertaken had that risk been properly explained to her. Put another way, even if there had been breach of the duty to obtain the informed consent of the patient, the injury complained of did not arise from that breach of duty.
(see paras 77–84, *post*.)

Failure to monitor foetal heart rate

[41] In relation to the contention that Dr Shyamala had failed to properly monitor foetal heart rate in accordance with accepted standards and the *Perinatal Care Manual* issued by the Ministry of Health, I found that this contention was not made out because:

(a) the requirements of the *Perinatal Care Manual* had in fact been adhered to by the defendants, as cardiotocography and doppler foetal rate readings had been taken within the prescribed timeframes; and

(b) I preferred the views of the defendant's obstetrics and gynaecology expert over that of the plaintiff, because the latter had come to the conclusion that the monitoring of foetal heart rate was sub-standard based on the mistaken premise that foetal heart rate readings had not been taken after 1940hrs, when in fact at least two further Daptone readings were taken before commencement of surgery.
(see paras 85–96, *post*.)

The contended delay in carrying out the ELSCS

[42] The court was of the view that the contentions by the plaintiffs that there had been a delay on the part of the relevant defendants to carry out the Emergency Lower Segment Caesarean Section and that this delay had breached the duty of care owed to the first and third plaintiffs had not been made out. The reasons I have come to this finding included the following:

(a) based on the evidence that had been received regarding the cardiotocography traces, I found that the cardiotocography readings were merely *suspicious* and not *abnormal*, and that the fetus suffered *acute* bradycardia and not *persistent* bradycardia;

(b) the case ought thus to have been classified in Category 2 in accordance with the guidelines issued by the UK National Institute for Health and Care Excellence, indicating maternal or foetal compromise which was not immediately life-threatening; and

(c) by these guidelines, the decision-to-delivery interval for Category 2 cases was 75 minutes. The delivery in this case was effected in 50 minutes, which established that there was no delay on the part of the defendants that contravened any duty of care owed to the first or third plaintiffs. (see paras 97–122, *post*.)

Other contentions of breach

[43] In relation to the other contentions of breach referred to in para 31(f) *ante*:

(a) I was of the view that there were no breaches of duty arising from the contended failure of Dr Siti Aziemah to monitor or observe the third plaintiff after the decision to carry out the Emergency Lower Segment Caesarean Section was made or to inform the on-call specialist immediately upon receiving the second call, or from the contended failure by Dr Shyamala to ask the registrar on-call to come immediately instead of asking her to be on standby and in proceeding with the Caesarean section on her own. The reason was that there were no procedures that were breached by reason of the actions of the two doctors;

(b) the contention that Dr Shyamala had failed to ring the alarm when she could not deliver the baby was not made out on the facts;

(c) the contentions that Dr Shyamala had failed:

(i) to put the plaintiff in a lithotomy position to facilitate the push method to address the impacted foetal head;

(ii) to lower the operating table in order to facilitate delivery;

(iii) to administer a uterine relaxant to the third plaintiff; and

(iv) to carry out intrauterine foetal resuscitation in order to increase blood flow to the fetus, prior to undertaking the Emergency Lower Segment Caesarean Section,

were all not pleaded in the statement of claim, and in the case of sub-paras (i) and (iv) above, had not been put to Dr Shyamala in the course of cross-examination;

(d) the allegation that Dr Shyamala had physically injured the baby in the course of delivery had not been proven by the plaintiffs in the course of trial, and that in any event, even if there had been bruises to the baby's body and limbs as a result of the Emergency Lower Segment Caesarean

Section, these injuries had not caused the cerebral palsy from which the first plaintiff suffers, and which formed the subject matter of the claim. (see paras 123–129, *post*.)

[44] As none of the contentions of breach of duty was made out against the director of the hospital, Dr Siti Aziemah, Dr Nurhafizi or Dr Shyamala, it followed that there was no vicarious liability on the part of the government.

[45] The summary of findings above are explained in further detail in, and should be read as being subject to, the paragraphs that follow below.

THE APPLICABLE PRINCIPLES

[46] In a claim for negligence, a plaintiff will need to establish the existence of a duty of care owed by the defendant to the plaintiff, he must prove that there was a breach of that duty of care, and that the breach had caused damage to the plaintiff, and finally it must be shown that the damage claimed was not too remote, in that it was a reasonably foreseeable consequence of the breach.

[47] The principles relating to the duty of care of medical practitioners have been explained in the Federal Court case of *Zulhasnimar bt Hasan Basri & Anor v Dr Kuppu Velumani P & Ors* [2017] 5 MLJ 438; [2017] 8 CLJ 605. They may be summarised as follows.

(a) a medical practitioner will owe a duty of care to his or her patient when advising, diagnosing and treating that patient;

(b) when considering whether there has been a breach of the duty to advise the patient, it is for the court to decide whether the patient has been properly advised: *Foo Fio Na v Dr Soo Fook Mun & Anor* [2007] 1 MLJ 593; [2007] 1 CLJ 229;

(c) by contrast, in connection with the duty to diagnose and treat the patient, the court will have regard to the practice accepted as proper by a responsible body of practitioners skilled in that particular art: *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118; and

(d) the court may, however, adopt a view that departs from the standards of the body of practitioners if those standards do not withstand logical analysis: *Bolitho v City and Hackney Health Authority* [1997] 3 WLR 1151.

[48] The accepted standards of medical practice can be established either through the publications of medical societies or by the opinion evidence of medical experts.

[49] Hospitals and the regulatory authority responsible for the medical practice (which in the case of Malaysia would be the Ministry of Health) may also publish operating procedures. If compliance with those procedures is mandatory, then it would appear to my mind that breach of those procedures may also be evidence of a breach of a duty of care. It may be observed that such mandatory operating procedures are conceptually distinct from standards published by medical societies, but breach of either will point to a breach of a duty of care. Where however a publication of a regulatory authority documents best practices or is expressed to be merely aspirational, then contravention of those best practices or aspirational standards may not necessarily point to a breach of a duty of care.

ANALYSIS AND DECISION

The existence of a duty of care

[50] It is well established in law that an attending physician would owe a duty of care to his or her patient.

[51] Whether a duty of care would be owed to a child who was not yet born at the time of the contended tort was not a question that was sought to be raised by the defence in this case. In the UK, the liability of a tortfeasor to an unborn child was created by statute, pursuant to its Congenital Disabilities (Civil Liability) Act 1976, suggesting that it is at least arguable that no cause of action would have arisen at common law. As this was not a point raised by the defence and no arguments were offered on it, I have proceeded on the basis that the existence of a duty of care to the first plaintiff was conceded by the defendants.

[52] Madam C, the third plaintiff, maintained the suit for and behalf of her son, the first plaintiff. Madam C sued as his litigation representative as well as in her personal capacity.

[53] By contrast, the second plaintiff sued only in his personal capacity. The second plaintiff, Mr L, is the first plaintiff's father. He claimed for special damages relating to (among others) the costs of renovations to the family home as well as to their motorcar, to accommodate the disability of the child. I fail to see how the defendants could have owed any duty of care to the second plaintiff as he was not himself a patient. Mr L would not have any personal cause of action against the defendants. On this basis, his claim ought to have been dismissed in limine. Be that as it may, the heads of claim that he claimed could have been claimed by the child, notwithstanding that the costs were incurred by the father.

[54] As explained, the after-trial written submissions for the plaintiffs offered no arguments on the liability of the six nurses and of nine of the 12 doctors who were made defendants in the action. I have considered the cases against these 15 defendants as having been abandoned. In any event, the evidence at trial showed that two of the doctors named as defendants (the tenth and eleventh defendants) had no involvement at all in the advice, diagnosis or treatment of Madam C. Hence they could not have owed any duty of care to the first or third plaintiffs.

[55] The first defendant in this case is the director of Hospital Tuanku Ja'afar. The director of a hospital, as the head of the hospital, would directly owe a duty of care to the patients of the hospital: *Pengarah Hospital Selayang & Ors v Ahmad Azizi bin Abdullah James & Ors* [2012] 5 MLJ 679; [2013] 3 CLJ 833.

[56] Having established that the first, fifth, eighth and ninth defendants owed a duty of care to the first and third plaintiffs, I now turn to the question of whether there has been breach of that duty of care. The allegations of breach by the defendants in the six areas that I have identified at para 31 *ante* are addressed in turn in the following paragraphs.

Doctors allegedly lacking in skill and experience

[57] It was advanced for the plaintiffs that:

(a) the first defendant had breached the duty of care that was owed by him to the first and third plaintiffs by failing to engage competent, skilled and experienced obstetricians and gynaecologists;

(b) Dr Norhafizi bt Madzaki (DW5, who was also the on-call specialist and the eighth defendant in the action) had failed to personally perform the Emergency Lower Segment Caesarean Section or to instruct a properly trained doctor to undertake the procedure who was able to deal with a fetus with a deeply impacted head;

(c) Dr Shyamala (DW3, who was also the ninth defendant in the action) did not have the requisite skill and technique to deliver a baby with a deeply impacted head; and

(d) Dr Shyamala had failed to provide a complete Privileges and Credential document with a supporting log book.

[58] No issue was raised by counsel for the plaintiffs regarding the skill and competence of Dr Siti Aziemah (DW4), the registrar on-call who completed the delivery. In as far as Dr Shyamala was concerned, a certificate issued by the Credentialing and Privileging Committee of Hospital Tuanku Ja'afar was exhibited at trial (B9/1393). This certificate indicates the types of procedures

that a doctor may undertake. It was common ground that before a doctor may be so certified, he or she must have first assisted another more senior doctor in performing those procedures. He or she must then also have performed those procedures under supervision.

[59] In order to obtain the requisite privileges and credentials, a log book must be submitted to the Credentialing and Privileging Committee. In the case of Dr Shyamala, this log book was never produced at trial. She explained that when she last received the certificate, it was not accompanied by the log book. She assumed that the log book had been discarded (NOE/292).

[60] The certificate for Dr Shyamala indicated that she was credentialed to undertake special procedures for the obstetrics and gynaecology discipline. Dr Shyamala explained when questioned by counsel for the plaintiffs that this meant that she was appropriately qualified to undertake Lower Segment Caesarean Sections (she explained at NOE/288 that she was credentialed to undertake all the procedures that Dr Siti Azeimah was qualified to carry out at the material time). Her answer was never challenged by counsel. She was also corroborated by Dr Siti Aziemah, who confirmed that Dr Shyamala was indeed credentialed to undertake an Emergency Lower Segment Caesarean Section (NOE/518).

[61] The contention advanced by the plaintiffs was also more nuanced than simply that she was not qualified to undertake an Emergency Lower Segment Caesarean Section. It was also alleged that Dr Shyamala was not versed in undertaking the pull method, also known as a reverse breech extraction, which was the method used by Dr Siti Aziemah to deliver the first plaintiff.

[62] There are two aspects to this issue. The first is that, it was established in evidence that before a doctor is credentialed to undertake a Caesarean section, the doctor must know both the pull method and the push method (see the answer by DW4 at NOE/428, lines 1–13) It must therefore follow that the contention that Dr Shyamala did not know how to undertake a reverse breech extraction cannot be correct. The fact that she had received the certificate established that she had undergone the requisite training.

[63] The second aspect is that the evidence showed that Dr Shymala was about to undertake the pull method when Dr Siti Aziemah arrived at the operating theatre and proceeded to deliver the baby.

[64] The push method entails inserting a hand into the mother's vagina and pushing the baby's head from below, to disengage it from the cervix. This was the method that Dr Shyamala was using, but she was not able to extract the

A baby. Dr Shymala explained that in such circumstances, the pull method is then employed. Mr Harmindar suggested in cross-examination that she was unable to perform the pull method. The following exchange was recorded at trial:

B Mr Harmindar: Ok, di sini doktor tidak dapat melakukan pull? Ya, ikut you punya notes.

Dr Shyamala: Bukan tidak dapat melakukan. Pada ketika saya sedang nak melakukan, Dr Aziemah sudah sampai untuk mengambil alih dan melakukan.

(NOE/354)

C

[65] The evidence thus showed that Dr Siti Aziemah had arrived at the operating theatre before Dr Shyamala could attempt a reverse breech extraction.

D

[66] The court therefore found that the contention that the doctors were not appropriately qualified or experienced had not been made out, as both doctors who attended to the patient in the operating theatre had been duly credentialed to undertake an Emergency Lower Segment Caesarean Section. The E credentialing process also meant that doctors would have been duly trained to perform both the push and the pull methods of extraction once they have received their certification.

[67] In as far as the contention that the delivery ought to have been F conducted by the on-call specialist, Dr Norhafizi Madzaki (DW5): counsel for the plaintiffs was not able to show that there was a requirement either in the operating procedures of the hospital or those issued by the Ministry of Health that required the on-call specialist to undertake an Emergency Lower Segment Caesarean Section personally.

G

[68] Finally, even if Dr Shyamala had failed to keep a copy of the log of the procedures that she had undertaken, this failure cannot be said to be the proximate cause of the injury to the first plaintiff.

H *No Emergency procedures for maternity cases; contended failure to follow MOH Guidelines*

[69] It was advanced for the plaintiffs that the first and second defendants (being the director of the hospital and the government of Malaysia respectively) I failed to establish standard operating procedures for maternity emergencies in Hospital Tuanku Ja'afar. It was further alleged that there was a failure to adhere to applicable guidelines issued by the Ministry of Health.

[70] At trial, counsel for the plaintiffs produced a document entitled *Labour*

Room Protocol used by Hospital Tengku Ampuan Rahimah in Klang (B5/950-1051). According to counsel, Hospital Tuanku Ja'afar in Seremban did not have equivalent procedures. If the *Labour Room Protocol* for the Klang hospital is examined closely, the following observations may be made:

(a) there are only two pages of the document that dealt specifically with Caesarean sections: a page dealing with the preparation of patients going for emergency Caesarean section (B5/970), and a page entitled 'Indication for Caesarean Section' (B6/1007), which provides guidance when making the determination whether surgical intervention is necessary; and

(b) significantly, the *Labour Room Protocol* provides for the guidelines for an obstetrics Red Alert System (B6/1001). However, there was nothing in the *Labour Room Protocol* that appeared to indicate that the Red Alert System was to be utilised for emergency Caesarean sections. The two indications given for the initiation of Red Alert were *post-partum collapse* and *obstetrics haemorrhage with shock*, none of which were present in the case under consideration.

[71] The defendants produced at trial a document entitled the *Policies and Procedures of the Department of Obstetrics and Gynaecology* (B1/76–101), which applied to Hospital Tuanku Ja'afar. According to counsel for the plaintiffs, this document was merely administrative in nature, and did not provide for the steps to be taken by medical personnel when faced with an emergency.

[72] There were two other documents that were referred to at trial, both issued by the Ministry of Health:

(a) the first was the *Perinatal Care Manual* (B4/703). This document described itself as a manual on perinatal care intended to be kept at hand for guidance to medical practitioners in the public sector. Section 3 of the *Perinatal Care Manual* deals with intrapartum care, although Caesarean sections do not appear to be addressed in this section. Section 3.11 of the *Perinatal Care Manual* refers to a Red Alert System, which is to be operationalised in all hospitals with obstetric cases. Section 3.11 (B5/820) reads as follows:

> 3.11 RED ALERT SYSTEM
>
> The Red Alert System is described in the Report on Confidential Enquiries into Maternal Mortality in Malaysia for the year 1992. It should be operational in all hospitals dealing with obstetric cases where it helps improve emergency response time and reduces maternal morbidity and mortality.
>
> a. How the Red Alert System functions
>
> – Red Alert is triggered in the presence of an emergency obstetric case in the

Casualty Department or the O&G Department

– The nurse or doctor in charge of the area activates the system by calling the telephone operator of the hospital and saying 'Red Alert'

– The operator will immediately initiate a 'call system' to get doctors involved to attend to this emergency.

– Each hospital is to establish its own system

– The doctors concerned (see below) will go to the area concerned

b. Staff involved in Red Alert

Medical officers on call	
Specialist on call	From O&G,
Consultant on call	Medical and
Blood Bank	Anaesthesiology
Sister on-call	Departments

c. Indications to activate Red Alert

– Severe antepartum haemorrhage

– Postpartum haemorrhage

– Intrapartum/postpartum collapse

– Eclampsia

– Uterine inversion

The excerpt above suggests that each public hospital with an obstetric unit is required to establish its own Red Alert System (see the fourth bullet point above). It may also be observed that none of the indications to activate Red Alert (in para (c) of the excerpt above) was present in the case under consideration; and

(b) the second document was entitled the *Operational Policy in Obstetrics and Gynaecology Services* (B6/1052) which was also issued by the Ministry of Health, and which is intended to be applied by hospitals managed by the Ministry of Health that are involved in obstetrics and gynaecology services. Paragraph 9.2.4 (B6/1099) of the *Operational Policy in Obstetrics and Gynaecology Services* appears to anticipate that there would be procedures for Red Alert, although the wording employed does not make it clear whether hospitals are required to promulgate their own procedures, or to adopt pre-existing polices issued by the Ministry.

[73] At trial, Dr Siti Aziemah (DW4) explained that the *Policies and Procedures of the Department of Obstetrics and Gynaecology* of Hospital Tuaku Ja'afar did not cover clinical matters. The standard operating procedures for clinical matters were discussed in morning meetings with the head of

department, which would be attended by all specialists and doctors. These directions of the head of department would be recorded in a note book maintained by the department. This note book was not produced at trial.

[74] Dr Nurhafizi Madzaki (DW5) further explained that the treatment for each patient is individualised and it would not be possible to have standard operating procedures for clinical matters because the treatment would differ from patient to patient. The treatment to be given will depend on the circumstances of each patient and the judgment call made by the doctor at the material time.

[75] To reiterate, the plaintiffs charged the defendants with not having adequate procedures to deal with emergencies, unlike Hospital Tengku Ampuan Rahimah in Klang. It was also advanced for the plaintiffs that the defendants had failed to follow guidelines issued by the Ministry of Health by not having proper standard operating procedures.

[76] I was of the view that these contentions were not made out for the following reasons:

(a) having carefully examined the *Labour Room Protocol* of Hospital Tengku Ampuan Rahimah in Klang, the only portion in it that could conceivably be said to deal with emergencies were the guidelines for an obstetrics Red Alert System. However, it was clear from the *Labour Room Protocol* (as well as from the *Perinatal Care Manual*) that the present case did not fall within any of the categories that justified the initiation of the Red Alert procedures;

(b) for the same reason, any failure on the part of the defendants to promulgate Red Alert procedures for Hospital Tuanku Ja'afar (in purported contravention with the guidelines issued by the Ministry of Health) would not be relevant in the present case, because this was simply not a Red Alert case. That this was so was also confirmed by Dr Joanne Lim at trial (NOE/260); and

(c) finally, the plaintiff failed to demonstrate that the manner in which the Department of Obstetrics and Gynaecology at the hospital recorded its clinical procedures were in contravention of guidelines issued by the Ministry of Health. There was nothing advanced in the written submissions that pointed to the contravention of any specific provision of any guideline.

Consent improperly obtained

[77] It was common ground that Madam C had signed a consent form to indicate her agreement to undergo the Emergency Lower Segment Caesarean Section. It was advanced for the plaintiffs that:

(a) the contents of the consent form and the risks and complications associated with the Emergency Lower Segment Caesarean Section was not adequately explained to Madam C;

(b) the form was not translated to Madam C in a Chinese dialect; and

(c) the consent of Madam C ought to have been obtained at the Patient Assessment Centre rather than the labour room. The position of the plaintiff was that the medical personnel would have had adequate time to explain the risks and complications to the patient in the Patient Assessment Centre instead of at the labour room.

[78] In this case, the decision to carry out an Emergency Lower Segment Caesarean Section was made in the labour room, after the patient was assessed by Dr Joanne Lim. That being the case, it would stand to reason that the consent of Madam C was obtained in the labour room, and not in the Patient Assessment Centre.

[79] Even though in her witness statement Madam C stated that the risks of the procedure had not been explained to her, when cross-examined, she conceded that she could not recall if the risks of the procedure had been explained to her (see NOE/71). She explained that she was experiencing pain at the time and that all she recalled was that she had signed the form (NOE/73).

[80] For its part, the defence did not lead oral evidence on who had in fact explained the risks of the procedure to the Madam C before the procedure commenced, or on the identity of the person who had obtained her consent. The documentary evidence (B1/129) showed that the patient's consent had been recorded by Dr Nurul Wahidah Wagimon (the sixth defendant) and witnessed by Dr Farha Hanina bt Md Saat (the 12th defendant). Neither of them were called to testify at trial.

[81] Dr Nurhafizi Madzaki (DW5) in her witness statement stated that, after delivery, she had explained the situation that had occurred to Madam C. Dr Nurhafizi testified that she had also met Madam C and her husband the following day, on 28 October 2017, where she explained the indications and complications faced in the operating theatre (Q&A 7 of WSD5). On 30 October 2017, Dr Nurhafizi held a Family Conference with Madam C and her husband. Dr Nurhafizi also testified that each time she had met Madam C

and her husband, she had explained to Madam C and her husband in Malay and that they had indicated to Dr Nurhafizi that they understood what was said to them (NOE/513). This suggests that Madam C and her husband had in fact understood Malay, contrary to her testimony at trial. Having evaluated all the surrounding circumstances of the case, I chose to believe the testimony of DW5 who was forthright and frank in her answers at trial.

[82] Even though Dr Nurhafizi had given an explanation to Madam C after the delivery and while the patient was still in the operating theatre, she had explained in cross-examination that she was not the doctor who had recorded the consent from Madam C (NOE/504).

[83] After carefully examining the evidence received at trial, I found as follows:

(a) the fact that the consent of Madam C was obtained in the labour room, and not in the Patient Assessment Centre, did not constitute a breach of a duty of care that was owed to Madam C or to the first plaintiff, because in this case, the decision to carry out the Emergency Lower Segment Caesarean Section was made when Madam C was in the labour room, and not when she was in the Patient Assessment Centre;

(b) the plaintiffs failed to discharge the evidential burden of proving that the risks and complications associated with an Emergency Lower Segment Caesarean Section had not been explained to Madam C before the procedure was carried out, as Madam C herself was not sure whether an explanation had been given to her. I further found that Madam C's contention that she could not understand Malay not to be true, on the basis of evidence to the contrary from Dr Nurhafizi (DW5); and

(c) in any event, the question of informed consent was not material to the real issue at hand: it was not the plaintiffs' case that Madam C would have refused consent had the risks of the procedure been adequately explained to her. The reality was that the doctors had made the right decision to carry out the Emergency Lower Segment Caesarean Section, because of the detection of foetal bradycardia. Properly understood, the plaintiffs' complaint was that the hospital personnel had breached their duty of care by the manner in which the Emergency Lower Segment Caesarean Section was carried out, and not that Madam C was exposed to a risk that she would not have voluntarily undertaken had that risk been properly explained to her. Put another way, even if there had been breach of the duty to obtain the informed consent of the patient, the injury complained of did not arise from that breach of duty.

[84] Had Madam C successfully discharged the evidential burden in para 83(b) *ante*, I would have drawn an adverse inference against the

A defendants for their failure to call the doctor who had purportedly explained the risks of a Lower Segment Caesarean Section to Madam C, and who had recorded her consent to the procedure. This, however, would not have changed my conclusion at para 83(c).

B *Failure to monitor foetal heart rate*

[85] It was alleged that Dr Shyamala failed to monitor foetal heart rate immediately before commencing surgery and that no reading of the foetal heart rate was taken between 1953hrs and 2012hrs.

C

[86] It will be recalled that in this case, cardiotocography readings were taken twice: one commencing at 1903hrs and another at 1933hrs. Cardiotocography allows the heart rate of the fetus to be recorded over a period of time. By contrast, a doppler foetal heat rate monitor (such as a Daptone device) only provides a snapshot of the current heart rate, and does not offer the ability to chart the heart rate for analysis.

D

[87] Hospital Tuanku Ja'afar did not have a portable cardiotocograph, and hence hospital personnel would use a Daptone device to check the heart rate of a fetus. In this case, a Daptone device was used twice in the operating theatre: once at 1950hrs and again at 1953hrs.

E

[88] It was advanced for the plaintiffs that Dr Shyamala Ponnuthurai (DW3) had breached her duty of care owed to Madam C and her baby by her failure to taking more frequent readings of foetal heart rate before commencing the Emergency Lower Segment Caesarean Section. Mr Harmindar for the plaintiffs argued that had the heart rate been taken before the procedure, the surgery could have been expedited and the injuries suffered by the first plaintiff could have been avoided.

F

G

[89] The *Perinatal Care Manual* issued by the Ministry of Health provides that a doppler foetal monitor reading should be taken every 15–30 minutes for mothers who are in labour. Cardiotocography monitoring, by contrast, ought to be carried out on the mother for 20 minutes on admission, where available (B5/812). It would appear from the evidence that both these requirements had been adhered to by the defendants: cardiotocography readings were taken twice (once more than prescribed by the *Perinatal Care Manual*), and doppler readings had been taken at 1930hrs, 1945hrs, 1950hrs and 1953hrs.

H

I

[90] At trial, two consultant obstetrician and gynaecologists were called by the parties to give opinion evidence: the plaintiffs called Dr Milton Lum Siew Wah (PW7) while the defendants called Dr Nor Fadzilah Mohd Yusof (DW8).

The obstetrics and gynaecology experts gave testimony simultaneously in an exercise commonly referred to as 'hot-tubbing'.

[91] Dr Milton Lum, the obstetrics and gynaecology expert appointed by the plaintiff, has been a consultant obstetrician and gynaecologist since 1983. He holds fellowships in the Royal College of Obstetricians and Gynaecologists and the Royal Society of Medicine. He is also a past president of the Malaysian Medical Association. His credentials were thus impeccable, a fact that can be attested by the numerous times his expert testimony was referred to in reported judgments involving medical negligence.

[92] Dr Lum was of the view that the monitoring of foetal heart rate was sub-standard. He explained in his expert report:

> 107. The monitoring of CCY's labour was sub-standard:
>
> (a) Despite the diagnosis of immediate threat to the life of the foetus i.e. foetal bradycardia (an abnormal CTG) at 1940 hours, there was no record of the foetal heart rate from 1940 hours onwards. The Caesarean section commenced at 2012 hours i.e. the foetal heart rate was not monitored for a period of about 32 minutes;
>
> (b) Although it is accepted practice that the foetal heart rate is checked upon arrival at the operating theatre, this was not done when CCY arrived at the operating theatre at 1950 hours.
>
> (See p 28 of encl 39.)

[93] Dr Lum's view was premised on his understanding that foetal heart rate had not been monitored between 1940hrs and 2012hrs. However, this was factually incorrect: Daptone readings were in fact taken at 1950hrs and 1953hrs.

[94] At the time of trial, Dr Nor Fadzilah Mohd Yusof was attached to Hospital Tengku Ampuan Rahimah in Klang. She had been a doctor for 25 years, 18 of which as a obstetrics and gynaecology specialist.

[95] Dr Nor Fadzilah was of the view that there was no breach of the standard of care in monitoring foetal heart rate. She correctly observed that cardiotocography readings had been taken twice and that a Daptone device was used to monitor foetal heart rate every five to ten minutes (see para 3 at p 41 of encl 126).

[96] Having carefully considered the evidence in this case and the submissions of counsel, I was of the view that the contention of the plaintiffs that the defendants had breached their duty of care to the first and third

plaintiffs by failing to properly monitor foetal heart rate had not been made out. The reasons for this conclusion were as follows:

(a) the requirements of the *Perinatal Care Manual* had in fact been adhered to by the defendants, as cardiotocography and doppler foetal rate readings had been taken within the prescribed timeframes; and

(b) as between the opinions of the plaintiffs' obstetrics and gynaecology expert, Dr Milton Lum (PW7) and the expert of the defendant, Dr Nor Fadzilah Mohd Yusof (DW8), I preferred the views of the latter. This was because Dr Milton Lum had come to a conclusion that the monitoring of foetal heart rate was sub-standard based on the mistaken premise that foetal heart rate readings had not been taken after 1940hrs, when in fact at least two further Daptone readings were taken before commencement of surgery.

Whether there had been delay in performing the ELSCS

[97] One of the key allegations of the plaintiffs was that there was a delay in carrying out the Emergency Lower Section Caesarean Section, which had resulted in the first plaintiff suffering hypoxia.

[98] At trial, the defendants included a document entitled *Guideline for Caesarean Birth* issued by the UK National Institute for Health and Care Excellence (the 'NICE Guideline') as part of the trial bundles. This guideline classifies four categories of cases in determining the urgency for Caesarean births. Category 1 cases are those where there exists immediate threat to the life of the mother or the fetus. For this category, Caesarean birth must be performed as soon as possible, and in most situations within 30 minutes of making the decision.

[99] Category 2 cases are where there are maternal or foetal compromise which is not immediately life-threatening. For Category 2 cases, Caesarean birth must also be performed as soon as possible, and in most situations within 75 minutes of making the decision.

[100] The relevant passages from the *NICE Guideline* state as follows:

> Classification of urgency for caesarean birth
>
> 1.4.2 Use the following standardised scheme to document the urgency of caesarean birth and aid clear communication between healthcare professionals:
>
> – Category 1. Immediate threat to the life of the woman or fetus (for example, suspected uterine rupture, major placental abruption, cord prolapse, foetal hypoxia or persistent foetal bradycardia).

– Category 2. Maternal or foetal compromise which is not immediately lifethreatening.

– Category 3. No maternal or foetal compromise but needs early birth.

– Category 4. Birth timed to suit woman or healthcare provider. [2004, amended 2021]

Decision-to-birth interval for unplanned and emergency caesarean birth

Category 1 caesarean birth is when there is immediate threat to the life of the woman or fetus, and category 2 caesarean birth is when there is maternal or foetal compromise which is not immediately life-threatening.

Perform category 1 caesarean birth as soon as possible, and in most situations within 30 minutes of making the decision. [2011, amended 2021]

Perform category 2 caesarean birth as soon as possible, and in most situations within 75 minutes of making the decision. [2011, amended 2021]

Take into account the condition of the woman and the unborn baby when making decisions about rapid birth. Be aware that rapid birth can be harmful in certain circumstances. [2011]

[101] Of note is the reference in Category 1 to *persistent foetal bradycardia*, as an indicator of immediate threat to life of the fetus. It will be recalled that in this case, while the fetus suffered bradycardia, his heart rate had recovered to normal on all three instances recorded in the cardiotocography traces.

[102] Dr Joanne Lim (DW2) was referred to the *NICE Guideline* by Mr Harmindar Singh Dhillon, lead counsel for the plaintiffs. Dr Lim's testimony was critical, because it appeared from the evidence that the categorisation of Madam C's case, as well as the decision to carry out an Emergency Lower Segment Caesarean Section, were both made by Dr Nuhafizi (the on-call specialist) in consultation with Dr Lim.

[103] In her witness statement, Dr Lim explained that the level of urgency in the patient's clinical situation was classified as Category 2 (maternal or foetal compromise that was not immediately life-threatening) (see Q&A 19 of WSD2). In cross-examination, paragraph 1.4.2 of the *NICE Guidelines* was specifically referred to Dr Lim by Mr Harmindar. She explained that the baby had suffered *acute bradycardia* and not *persistent bradycardia*. Persistent bradycardia is when the foetal heart rate drops to 60-80 bpm and this situation is prolonged for at least three minutes (see NOE/240). In the present case, the foetal heart rate had dropped to 60 bpm for one minute, but thereafter recovered to its baseline, meaning that the baby had acute bradycardia. This then was the reason why the case was classified as Category 2. It may be observed that Dr Lim's testimony did not waver under cross-examination. When further pressed by Mr Harmindar, the following exchange took place:

A Mr Harmindar: Normally what time rate is an emergency should be completed in?

Dr Lim: Well, it depends on the category of the caesarean section. Based on the *NICE Guidelines* there's category 1, 2, 3, 4. For this patient she's categorised, her category is category 2.

B (NOE/254)

[104] From the above, it would appear that the applicable standard of care specifies the decision-to-birth interval as 75 minutes. The actual decision-to-birth interval in this case was 50 minutes (from 1940hrs to C 2030hrs), well within the standard stipulated by the *NICE Guideline*.

[105] In his written submissions, Mr Harmindar sought to assail the *NICE Guideline* on a number of points:

D (a) first, it was pointed by Mr Harmindar that the *NICE Guideline* was only served on the solicitors for the plaintiffs approximately a week prior to trial. I was of the view that it would not lie in the mouths of the plaintiffs to complain about the inclusion of the document when no objection was raised at trial, and more so when it was Mr Harmindar himself who had E referred Dr Joanne Lim to the *NICE Guideline*;

(b) second, it was pointed out that the *NICE Guideline* did not form any part of the standard operating procedure for Hospital Tuanku Ja'afar. This is undeniably true, but the real question was not whether it formed F part of the standard operating procedures of the hospital, but rather whether it fulfilled the *Bolam* test: was it representative of the practice accepted as proper by a responsible body of skilled medical practitioners? In my view it does, as it was issued by the UK National Institute for Health and Care Excellence;

G (c) third, it was pointed out that the *NICE Guideline* was only published on 31 March 2021, when the events complained of occurred in October 2017. It was argued that, as such, the defendants could not conceivably have had the *NICE Guidelines* in mind at the material time. There are two answers to this point. The first is that the *Caesarean Birth* H *Guideline (NG192)* had superseded an earlier document entitled *Caesarean Section Guideline (CG132)* issued in November 2011 (see p 4 of the NICE Guideline at B10/1457 of the trial bundles). That there existed an earlier guideline can be also seen from the excerpt reproduced at paragraph 100 *ante*. There was thus a predecessor guideline issued by I NICE which operated at the time of the events complained of. The second is that, even though past practice should not be judged by more stringent modern standards (see *Roe v Ministry of Health and another* [1954] 2 QB 66), the obverse proposition is not necessarily true. If the state of medical knowledge has advanced, such that an act would no

longer contravene a modern standard, the court would not knowingly impose upon a defendant the more stringent but superseded standard. Progress, it must be said, moves only in a single direction.

[106] Mr Harmindar also referred Dr Lim to the *Operational Policy in Obstetrics and Gynaecology Services* issued by the Ministry of Health, which are intended to be applied by hospitals managed by the Ministry of Health that are involved in obstetrics and gynaecology services. This policy provides:

2. Patient's pre-operative preparation shall be done appropriately;

...

k. Time for decision to caesarean section is less than 30 minutes. (B6/1099)

[107] When asked by Mr Harmindar as to whether this policy requires the Caesarean section to be completed within 30 minutes, Dr Lim replied that this merely provides that surgery must be *commenced* within 30 minutes from the time the decision was made for a Caesarean section (NOE/229). Dr Lim was not challenged in her answer.

[108] In any event, even if sub-para k was intended to refer to the decision-to-delivery interval, the *Operational Policy in Obstetrics and Gynaecology Services* do not purport to impose requirements that are to be construed as minimum standards. The policy contains the following disclaimer (B6/1060):

DISCLAIMER

There are many variations in the design, location, facilities, support services and the presence or absence of subspeciality services in the hospitals managed by the Ministry of Health. There are also variations in human resources managing the obstetric and gynaecological services located in these hospitals in terms of numbers, experience levels, training and capability. There are numerous factors accounting for these variations, many of which are beyond the control of the Ministry of Health. These variable facilities and resources dictate that the same practices cannot be carried out in all hospitals at the current time.

The operating policies are practices which should be within the capability of most hospitals but not necessarily all. The policies outlined in this document will be aimed for by those involved in the O&G services of Malaysia. Efforts will be made by all concerned in the planning, operational activities and evaluation of such services to ensure that the majority of hospitals would be able to adhere to these policies and standards. However, it should be clearly understood that *the operating policies listed here are not the minimum standards that should be found in all hospitals* and should not carry any adverse inference in any hospital that cannot comply with these policies due to the reasons stated above. Hospitals will continue to be accountable for all the services that they provide in good faith for the benefit of the patients that they serve. (Emphasis added.)

The O&G expert testimonies on the issue of delay

[109] As explained at para 12 *ante*, the consultant obstetrician and gynaecologists who were called to give expert testimony were given copies of the two cardiotocography traces recorded at 1903hrs and 1933hrs on 27 October 2017, but neither cardiotocography trace was legible in the copies provided. This was because the cardiotocography traces had been recorded on thermal paper, and by the time the copies were provided to the experts, the ink on the cardiotocography traces had significantly faded. The copies made available to the court at trial, however, were marginally better as these were printed from colour image files.

[110] As a result, both the obstetrics and gynaecology experts prepared their respective reports without having the benefit of the data that had been recorded in the cardiotocography traces.

[111] Dr Milton Lum (the expert for the plaintiffs) was of the view that there had not been adherence to the applicable standards of care because of the delay in the delivery. Dr Lum referred to a document issued by the Royal College of Obstetricians and Gynaecologists in London entitled *Classification of Urgency of Caesarean Section — a Continuum of Risk (Good Practice No 11)* in support of his view that the decision-to-delivery interval ought to have been 30 minutes. The 50 minutes taken in this case, according to Dr Lum, constituted a breach by the relevant defendants of the duty of care that they owed to the first and third plaintiffs. The relevant passage in Dr Lum's report stated as follows:

> Decision delivery interval
>
> The degree of urgency of Caesarean section is classified according to the presence or absence of maternal or foetal compromise i.e. Category 1 when there is immediate threat to the life of mother or foetus; Category 2 when there is no immediate threat to the life of mother or foetus; Category 3 when early delivery is required and Category 4 when the Caesarean section can be done at a time to suit the mother and the maternity services.
>
> 'Once a decision to deliver has been made, therefore, delivery should be carried out with an urgency appropriate to the risk to the baby and the safety of the mother. A target DDI for Caesarean section for 'foetal compromise of 30 minutes is an audit tool that allows testing of the efficiency of the whole delivery team and has become accepted practice, however, certain clinical situations will require a much quicker DDI than 30 minutes' ...
>
> (Royal College of Obstetricians and Gynaecologists. Classification of urgency of Caesarean section — A continuum of risk. April 2010 page 2)
>
> This was a Category 1 Caesarean section i.e. there was immediate threat to the life of the foetus, in that the CTG was abnormal. The decision to perform a Caesarean section was made at 1940 hours and LET was delivered at 2030 hours i.e. the decision delivery interval was 50 minutes which was in excess of the audit target of

30 minutes. This was not in accordance with the Health Ministry's standard operating procedure for foetal heart rate abnormalities i.e. expedite delivery as appropriate (PCM page 131).

[112] There are two important points to be made on Dr Lum's report in respect of the issue of delay:

(a) the first is that the actual words employed in the *Classification of Urgency of Caesarean Section — A Continuum of Risk (Good Practice No 11)* are not as unequivocal as Dr Lum suggests; and

(b) second, the document *Classification of Urgency of Caesarean Section — A Continuum of Risk (Good Practice No 11)* issued by the Royal College was supplanted by the *NICE Guideline* as at 21 October 2021.

These two points are explained in turn in the following paragraphs.

[113] The full text of the relevant passage in *Classification of Urgency of Caesarean Section — A Continuum of Risk (Good Practice No. 11)* is reproduced below:

> *Urgency*
>
> The Sentinel caesarean section audit suggested that in cases, such as cord prolapse, a DDI of 15 minutes was feasible. However, in many category-1 cases, delivery within 30 minutes was not achieved. Delivery within 75 minutes does not appear to increase the risk of compromise, while delivery within 30 minutes may not always result in a good antenatal outcome. Once a decision to deliver has been made, therefore, delivery should be carried out with an urgency *appropriate to the risk to the baby and the safety of the other*. Units should strive to design guidelines that result in the shortest safety achievable DDI. Evidence suggests that any delay is used usually associated with the delay in transfer to theatre.
>
> *A target DDI for Caesarean section for 'foetal compromise' of 30 minutes* is an audit tool that allows testing of the efficiency of the whole delivery team and has become accepted practice; however:
>
> – certain clinical situations will require a much quicker DDI than 30 minutes and units should work towards improving their efficiency
>
> – undue haste to achieve a short DDI can introduce its own risk, both surgical and anaesthetic, with the potential for maternal and neonatal harm. (Original emphasis.)

[114] The passage reproduced above appears to state that 30 minutes should be the *target* decision-to-delivery interval in Caesarean sections, but that a 75 minute decision-to-delivery interval would be acceptable as the risks are not appreciably increased. Put another way — in legal vocabulary — 30 minutes would be the best practice, but delivery within 75 minutes would not constitute breach of the applicable standard of care.

[115] No less significant is that fact that, by the time the obstetrics and gynaecology experts testified at trial on 16 June 2022, the document *Classification of Urgency of Caesarean Section — A Continuum of Risk (Good Practice No 11)* had appeared to have been archived and supplanted by the *NICE Guideline*. The following is a screen capture of the relevant URL (https://www.rcog.org.uk/guidance/browse-all-guidance/good-practice-papers/classification-of-urgency-of-caesarean-section-a-continuum-of-risk-good-practice-no-11/) of the Royal College of Obstetricians and Gynaecologists:

[116] Even though the fact of the supersession of the document *Classification of Urgency of Caesarean Section — A Continuum of Risk (Good Practice No 11)* was not brought to the attention of the court at trial or in the course of oral submissions, I was of the view that this is a matter of which the court was entitled to take judicial notice, by the proper operation of s 57(2) of the Evidence Act 1950, which provides (among others) that the court may resort for its aid appropriate documents of reference in matters of science.

[117] Dr Nor Fadzilah Mohd Yusof (DW8), who was the obstetrics and gynaecology expert called by the defence, stated in her report that there had been a delay in the delivery of the first plaintiff. She thus agreed with the views of Dr Milton Lum. According to Dr Nor Fadzilah, the delay was because of the complications arising from the existence of fibroids and because the head of the fetus had been deeply engaged. The following was the relevant passage in her report:

> 10. Sama ada plaintif telah dilahirkan dalam tempoh masa yang dibenarkan
>
> Terdapat kelewatan semasa proses kelahiran. Decision delivery interval adalah 50 minute. Ini disebabkan kes Ibu Plaintif adalah kompleks, terdapat fibroid di lower segment menyebabkan incision dilakukan agak tinggi (untuk mengelakkan incision pada fibroid yang mengakibatkan komplikasi pendarahan) dan kepala bayi adalah deeply engaged.

[118] It will be recalled that:

(a) the existence of fibroids had in fact never formed any part of the defendants' pleaded case (see paras 33 and 34 *ante*). Even though the existence of fibroids was referred to in the defence, the position taken by the defence was that the treatment of the patient would not have differed even if the existence of the fibroids had been made known to hospital staff; and

(b) the experts' opinions were made without the benefit of the data in the cardiotocography traces.

[119] At trial, the court explained to the obstetrics and gynaecology experts that whether or not the cardiotocography reading ought to have been categorised as *suspicious* or *abnormal*, and whether or not there had been acute bradycardia or persistent (or prolonged) bradycardia was a question of fact to be determined by the court (see, for example, NOE/579). The experts were asked by the court, had the cardiotocography readings been merely *suspicious* and not *abnormal*, would the expert in question still have categorised the case in Category 1 (indicating foetal or maternal compromise)?

[120] Dr Milton Lum answered in the affirmative but did not support his answer by reference to the document *Classification of Urgency of Caesarean Section — A Continuum of Risk (Good Practice No 11)* issued by the Royal College of Obstetricians and Gynaecologists (ibid).

[121] By contrast, Dr Nor Fadzilah explained that she would have categorised the case as Category 2 (NOE/580. See also NOE/654 when Dr Nor Fadzilah was being re-examined by Senior federal counsel)

Findings of the court regarding the contention of delay

[122] The court was of the view that the contentions by the plaintiffs that there had been a delay on the part of the relevant defendants to carry out the Emergency Lower Segment Caesarean Section and that this delay had breached the duty of care owed to the first and third plaintiffs had not been made out. The reasons I have come to this finding are as follows:

(a) based on the evidence that had been received regarding the cardiotocography traces from the testimonies of Dr Muhammad Fahmi (DW1) and Dr Joanne Lim (DW2), I found that the cardiotocography readings were merely *suspicious* and not *abnormal*, and that the fetus suffered *acute* bradycardia and not *persistent* bradycardia;

(b) Dr Joanne Lim was thus correct to have categorised the case as Category

2, indicating maternal or foetal compromise which was not immediately life-threatening;

(c) Dr Joanne Lim was not challenged in cross-examination on this point. The failure to put the plaintiffs' case to the material witness of the defendants in cross-examination offended the rule in *Browne v Dunn* (1893) 6 R 67 (HL) and meant that the issue was not competent to be raised in submissions subsequently. The scope of this rule was explained by Gopal Sri Ram JCA in *Aik Ming (M) Sdn Bhd & Ors v Chang Ching Chuen & Ors and another appeal* [1995] 2 MLJ 770; [1995] 3 CLJ 639 (although this case was reversed by the Federal Court in *Pekan Nenas Industries Sdn Bhd v Chang Ching Chuen & Ors* [1998] 1 MLJ 465; [1998] 1 CLJ 793 on other points, the decision of the Court of Appeal remains good law on this point) in the following terms:

> It is essential that a party's case be expressly put to his opponent's material witnesses when they are under cross-examination. A failure in this respect may be treated as an abandonment of the pleaded case and if a party, in the absence of valid reasons, refrains from doing so, then he may be barred from raising it in argument. It is quite wrong to think that this rule is confined to the trial of criminal causes. It applies with equal force in the trial of civil causes as well.

(d) even though both obstetrics and gynaecology experts were of the initial view that there had been delay in the delivery of the first plaintiff, they did not have the benefit of the data in the cardiotocography traces for the purposes of preparing their reports;

(e) when asked if their answers would change if the cardiotocography readings were merely *suspicious* and not *abnormal*, Dr Milton Lum persisted in his view that the case ought to have still been categorised as Category 1, whereas Dr Nor Fadzilah categorised the case as Category 2. I preferred the views of Dr Nor Fadzilah over those of Dr Lum because:

(i) the document relied upon by Dr Lum — *Classification of Urgency of Caesarean Section — A Continuum of Risk (Good Practice No. 11)* issued by the Royal College of Obstetricians and Gynaecologists — appeared to suggest that a decision-to-delivery interval of 30 minutes or less would be the best practice, but delivery within 75 minutes would not constitute breach of the applicable standard of care; and

(ii) in any event, by the time of trial, this document had been superseded by the *NICE Guideline*;

(f) I was of the view that the *NICE Guideline* was representative of the practice accepted as proper by a responsible body of skilled medical practitioners, and thus satisfied the *Bolam* test;

(g) that the *NICE Guideline* was issued after the incident that formed the subject matter of the plaint was irrelevant, for the reasons explained at paragraph 105(c) *ante*; and

(h) by the *NICE Guideline*, the decision-to-delivery interval for Category 2 cases was 75 minutes. The delivery in this case was effected in 50 minutes, which established that there was no delay on the part of the defendants that contravened any duty of care owed to the first or third plaintiffs.

Other contentions of breach

[123] The written submissions of counsel for the plaintiffs contained several other contentions of breach levelled against the defendants. I deal with these allegations in the following paragraphs.

[124] The first group of allegations may be conveniently dealt with together. These allegations were made against Dr Siti Aziemah bt Jahaya (DW4) and Dr Shyamala Ponnuthurai (DW3). It was alleged that Dr Siti Aziemah had breached her duty of care to the plaintiffs when she:

(a) failed to monitor or observe the third plaintiff after the decision to carry out the Emergency Lower Segment Caesarean Section was made; and

(b) failed to inform the on-call specialist immediately upon receiving the second call.

[125] Against Dr Shyamala, it was further advanced for the plaintiffs that:

(a) Dr Shyamala had breached her duty of care to the plaintiffs when she failed to ask the registrar on-call (Dr Siti Aziemah) to come immediately instead of asking her to be on standby; and

(b) Dr Shyamala was negligent in not waiting for the Dr Siti Aziemah, and instead proceeding with the Caesarean section on her own.

[126] I was not satisfied that the actions of the two doctors constituted a breach of established procedures of the hospital. For instance, there was no procedure that required Dr Siti Aziemah, as the registrar on-call, to personally monitor or observe a patient before surgery was undertaken. Similarly, there was no requirement for the attending surgeon to request the presence of the registrar on-call, or for the registrar on-call to alert the on-call specialist. In addition, because Dr Shyamala was appropriately credentialled to undertake the procedure in question, she was entirely correct to proceed with the surgery on her own.

[127] It was further alleged that Dr Shyamala had failed to ring the alarm when she could not deliver the baby. This contention was not made out, as Dr

Shyamala had in fact requested the presence of the registrar on-call at 2020hrs after she had encountered difficulties. It has to be remembered that Dr Shyamala had started the surgery at 2012hrs, which meant that Dr Siti Aziemah was called just eight minutes after the surgery had commenced. As can be seen from the discussion and analysis at paragraphs 97 to 122 *ante*, I have found that there had not been any delay in the delivery.

[128] There were another set of allegations made against Dr Shyamala set out in the written submissions of counsel for the plaintiffs. I found that these allegations had not been pleaded in the statement of claim, and hence did not properly form part of the plaintiffs' case against the defendants. In addition, two of these allegations had also not been put to Dr Shyamala, and could not therefore be raised in submissions by reason of the operation of the rule in *Browne v Dunn.* These contentions, and my findings in respect of them, are summarised in the following table:

	Allegation	Finding
(a)	Dr Shyamala failed to put the plaintiff in a lithotomy position to facilitate the push method to address the impacted foetal head.	This point was not pleaded in the statement of claim. In addition, the contention had not be put to Dr Shyamala in cross-examination.
(b)	Dr Shyamala failed to lower the operating table in order to facilitate delivery.	This point was not pleaded in the statement of claim.
(c)	Dr Shyamala did not administer a uterine relaxant to the third plaintiff.	This point was not pleaded in the statement of claim.
(d)	Dr Shyamala did not carry out intrauterine foetal resuscitation in order to increase blood flow to the fetus, prior to undertaking the Emergency Lower Segment Caesarean Section.	This point was not specifically pleaded in the statement of claim, save in general terms at paragraph (af) at page 28 of the bundle of pleadings. In any event, the contention had not be put to Dr Shyamala in cross-examination.

[129] The final allegation against Dr Shyamala was that she had physically injured the baby in the course of delivery. I was of the view that this allegation had not been proven by the plaintiffs in the course of trial. In any event, I found that the hypoxic ischaemic encephalopathy suffered by the first plaintiff had been caused by compression of the umbilical cord, which had the effect of restricting blood flow to the fetus. Thus, even if there had been bruises to the baby's body and limbs as a result of the Emergency Lower Segment Caesarean

Section, these injuries had not caused the cerebral palsy from which the first plaintiff suffers, and which formed the subject matter of the claim.

CONCLUSION

[130] The events surrounding the first plaintiffs' birth were undeniably tragic. He is left to live out the rest of his life in a state of permanent disability, and will require extensive specialised care.

[131] However, the injuries he suffered were not the result of negligence on the part of the defendants. The evidence in this case showed that the umbilical cord had been wrapped itself around both the baby's hips while in the womb, making it likely that there had been cord compression when Madam C went into labour. The cardiotocography readings established acute bradycardia even before surgery had commenced, suggesting foetal distress unrelated to the subsequent actions of Dr Shyamala or Dr Siti Aziemah. In cross-examination, Dr Siti Aziemah accepted the possibility that the fact that the umbilical cord had wrapped itself around the hips of the first plaintiff had caused reduced oxygen flow to the first plaintiff before his birth, causing hypoxia and ultimately brain damage (NOE/455). Both obstetrics and gynaecology experts were also in agreement that cord compression could have been the mechanism for the hypoxic event (see the summation by the court on this issue in the course of hot-tubbing, at NOE/594).

[132] The entanglement of the cord occurred through no fault of the defendants, and had occurred intrauterine. In cross-examination, Dr Naveen Nair (DW7, the paediatric specialist who attended to the first plaintiff upon his birth) explained that it was possible that hypoxia had already occurred before delivery, and that the outcome would have been the same regardless of the time taken to deliver the baby (NOE/563). The evidence adduced in this case showed that the nurses and doctors attending to the first and third plaintiffs had undertaken the Emergency Lower Segment Caesarean Section as best they could, and certainly without breach of any duty of care owed to Madam C and her son.

[133] For the reasons explained in this judgment, the entirety of the plaintiffs' claim against the defendants was dismissed. The plaintiffs have failed to establish that there had been a breach of any duty of care owed to them by the first, fifth, eighth or ninth defendants. Consequently, the case against the second defendant for vicarious liability was also dismissed. I directed that the plaintiffs bear costs. With the circumstances of the case in mind, I determined costs to be RM10,000, even though the trial consumed seven days.

A POST-SCRIPT

[134] The task faced by the court in conducting the trial in this case, and in making a determination on the merits, was hampered not only by the manner in which the defence had conducted its case *Child A (a minor suing through his mother and litigation representative, Cheah Chai Yuen) & Ors v Pengarah Hospital Tuanku Ja'Afar, Seremban & Ors* [2023] 7 MLJ 603; [2022] 7 CLJ 391 — which had led to the issuance of unless orders—but also by the quality of the submissions advanced, which in my respectful view fell far below the standards expected of counsel. The court struggled to understand the precise nature of many of the arguments advanced by the plaintiffs because the submissions suffered from a chronic lack of organisation, with contentions of breach peppered liberally throughout the written submissions. It was left to the court to impose order and rigour to the points raised in order to properly analyse the contentions of breach.

[135] Worse, the manner in which counsel for the defendants presented the rebuttal submissions left the court guessing as to true nature of the counter arguments being advanced. There were blanket references to the testimonies of witnesses, without any effort made to identify where in the notes of evidence the relevant passages were. It was only after the intervention of the court that this shortcoming was addressed, but even then in the most unsatisfactory fashion. Instead of summarising counsel's understanding of the evidence and including a cross-reference to the relevant pages of the notes of evidence, the further submissions merely reproduced *in extenso* passages from the notes of evidence, without any intelligible summary. To compound matters, for reasons best known only to counsel, the notes of evidence were reproduced entirely in capital letters, making the whole extremely difficult to read. The submissions of the defence also left many of the plaintiffs' contentions of breach unaddressed (such as the points in para 128 *ante*).

[136] The court was left with the toilsome task of itself having to trawl through the notes of evidence and the trial bundles to ascertain the merits of the case, without the benefit of assistance customarily expected from counsel. This is of course less than ideal, not just from the perspective of the management of court time, but it also raises questions as to whether the respective litigants' best case was put before the court.

Plaintiffs' claim dismissed with costs of RM10,000.

Reported by Dzulqarnain Ab Fatar